Office of the Inspector General Report to the Governor and General Assembly (Jan. 2024)

Death and Serious Injury Investigations

OIG2024 Death Investigation #2

DEATH

A 24-year-old mother found her 4-year-old medically complex child unresponsive, and an ambulance transported the child to the hospital, where medical staff pronounced the child deceased. The pathologist reported the child had cocaine in her system, and the amount was more than twice the dose that would be fatal for a healthy adult. The medical examiner's report determined the cause of death as cocaine toxicity and ruled the manner of death as homicide. The medically complex child could not have ingested the cocaine herself, as she required feeding through a tube and lacked the motor skills to put the substance in her mouth. The child's mother and the mother's paramour tested positive for cocaine the day of the child's death, and the mother and the paramour were held without bail in jail on charges of first-degree murder and drug-induced homicide. The Department indicated the mother and the paramour for death by abuse (#1) and substance misuse by abuse (#15). Six days prior to the child's death, the Department initiated an investigation against the mother for medical neglect (#79) and environmental neglect (#82) to the child that remained open at the time of the child's death.

INVESTIGATION

In October 2018, the then 9-month-old child first came to the attention of the Department after she was brought to the hospital and medical staff determined she had a hypoxic brain injury. The reporter told the DCFS hotline that a metabolic disease could have caused the injury, or it could be from oxygen cut-off or shaking. The OIG obtained the child's medical records, in which physicians documented the following diagnoses: hypoxic ischemic encephalopathy, status epilepticus-generalized convulsive, obtundation, hypoglycemia, acute respiratory failure, and an altered mental status. Almost two months later, the hospital discharged the child to her mother and father. The following week, the Department unfounded the mother and father for head injuries by neglect (#52) because medical staff ruled out abuse by the parents and reported the child ingested medicine that caused the brain hypoxia. The day prior to the child's hospital admission, a family friend watched the child for the parents, and the parents believed the child may have ingested the family friend's diabetes medication. As a result of the incident, the child sustained permanent and severe brain damage, and the child required a wheelchair, was non-verbal, and depended on others for all her basic needs.

Six days prior to the child's death, the DCFS hotline received a report that the 4-year-old medically complex child required tube feedings and lost a lot of weight in the prior two weeks because of difficulty with child's feedings. The reporter stated the child had a fever, had been vomiting for a week, and had a rash all over her face. The reporter stated the mother had not taken the child to the doctor, and that the reporter attempted to call the mother that day, but the mother did not respond. The reporter also stated that it did not appear that the child bathed regularly, the mother and child previously smelled of marijuana, and the child came to school with the same clothes on that she wore the day before, with vomit still on her clothes. The Department opened the investigation for allegations of medical neglect (#79) and environmental neglect (#82) against the mother.

The same day as the hotline call, the assigned child protection investigator attempted to see the mother and child at their home, but no one answered the door. The investigator called the mother, and they discussed the child's condition, to which the mother stated that the child had trouble with feedings the prior week and vomited, but had no fever. The mother reported she contacted the child's dietitian, who replied via email with recommendations and a plan of action. Without prompting, the mother stated that she planned to take the child to the clinic the following day. The mother agreed to contact the child protection investigator to confirm she brought the child to the clinic. The mother also agreed to forward the dietitian's email to the investigator, which the mother did later that day.

The day after the hotline call, the child protection investigator exchanged a series of text messages with the mother to confirm that the mother took the child to the clinic. The mother confirmed that an advanced practice registered nurse saw the child at the clinic and the mother provided the nurse with the investigator's contact information. The child protection investigator contacted the nurse, who verified she saw the child at the clinic. The nurse stated she discharged the child to the mother due to no outward signs of abuse or neglect. The child protection investigator discussed the medical neglect allegations, and the nurse responded that the mother appeared active in caring for the child since the mother seemed well informed about the child's condition. The child protection investigator told IG investigators that he discussed the child's weight loss with the nurse, who reported the child's illness and vomiting could have possibly caused the weight loss. When asked if he attempted to see the child during the medical exam, the child protection investigator told IG investigators that he did not discuss it with the mother, and that she had taken the child to the clinic outside his working hours.

Following the communications with the nurse, the child protection investigator staffed the investigation with another child protection investigator who was temporarily assigned as a supervisor, as the permanent supervisor was on vacation. The temporarily assigned supervisor instructed the investigator to see the child in person on their next scheduled workday, two days later. The temporarily assigned supervisor told IG investigators that given that the medical professional saw the child, she thought it was sufficient to delay the requirement to observe the child in-person. The temporarily assigned supervisor reported basing the decision on the facts that the report was not coded as an emergency response, the family had no prior reports of environmental neglect, and the concerns about the child's presentation came from someone that had never been in the home.

The temporarily assigned supervisor told IG investigators that she never followed up with the child protection investigator about seeing the child when the investigator returned to work two days later because the temporarily assigned supervisor no longer had temporary assignment as the supervisor. In a separate interview, the child protection investigator told IG investigators that he did not see the child in person due to responding to a report on a different investigation in a different city. The child protection investigator's permanent supervisor separately confirmed to IG investigators that the child protection investigator had initiated two newly assigned investigations that day, as the field office was understaffed. The permanent supervisor told IG investigators that she did not recall when she reviewed the investigation involving the medically complex child after her return from a 10-day vacation, and she had to review all the investigative reports assigned to her team from that time period. The permanent supervisor told IG investigators that child protection staff should not have gone two days without trying to see the child in person. The permanent supervisor also stated that currently there was no real time way for supervisors to know if an investigator saw the child or attempted to see the child until the investigator entered their contact notes in SACWIS. The permanent supervisor stated she relied on meeting with the child protection investigators to determine if a child had been seen.

Six days after the Department initiated the investigation, the DCFS hotline received a report of the child's death. In those six days, the child protection investigator did not contact the hotline reporter, observe the child or the home environment, interview the mother in person, or contact the child's physicians or specialists. The child

death investigator interviewed the child's primary care physician, who worked at the same facility as the nurse who evaluated the child five days prior to her death. The primary care physician informed the child death investigator that the child needed to be seen every month for a weight check, but the mother did not comply with the weight checks, and the mother did not respond to the physician's calls or letters to their residence. The OIG obtained the child's medical records, which documented the child weighed 23.8 lbs. the week prior to her death, a weight loss of 7 lbs. from the last documented weight check two months earlier of 30.42 lbs.

The child death investigator also interviewed the child's school nurse, who reported she had regular contact with the child's physician and dietician because of the mother's lack of cooperation. The school nurse stated that two months prior to the child's death, the mother sent the child to school without enough formula for her feeding. The child's teacher also told the child death investigator that the mother ran out of formula about a month and a half earlier, and the school provided the child with formula which she did not tolerate well. The teacher stated that the school staff had concerns about the child's hygiene and weight loss.

Less than two months after the hotline call regarding the medically complex child's weight loss, the Department indicated the mother for medical neglect (#79) and environmental neglect (#82). According to the rationale, the child's primary care physician completed the CANTS 65-B, Evaluation of Medical Neglect of a Child and documented medical neglect of the child which contributed to her worsening condition and placed the child at risk for a serious outcome.

RECOMMENDATIONS

1. A copy of this report should be shared with the child protection investigator, the temporarily assigned supervisor, and the permanent supervisor for training purposes.

The Department agrees. The report was shared with the involved staff and used as a training tool.

2. The Department should explore technology that provides real time information for better oversight and coordination for child protection supervisors to ensure children are being seen in a timely manner. This data should allow for a distinction between when a child is physically seen and when a good faith attempt was made but the child was not seen.

The Department agrees. The Department of Child Protection and the Department of Information and Technology (DoIT) are committed to exploring technology with the ongoing development of IllinoisConnect that will provide greater oversight and coordination for child protection supervisors. This technology will enhance current data provided through PowerBI, which provides a distinction between victims seen and documented and victims not seen and/or documented.

3. This report will be redacted and used by the OIG in Error Reduction trainings.

The redacted report has been shared with IG training staff for inclusion in OIG Error Reduction Trainings. See also, Part IV: Error Reduction Training.

4. A redacted copy of this report should be shared with the clinic where the child was seen prior to the death.

The report was shared with the administrators of the clinic.